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Lisbet Borge [a]; May Solveig Fagermoen [b]
[a] Hedmark University College, Faculty of Health and Sports, Vikersund
[b] Aker University Hospital & University of Oslo, Institute of Nursing and Health Sciences, Oslo, Norway

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Patients' core experiences of hospital treatment: Wholeness and self-worth in time and space

LISBET BORGE[1] & MAY SOLVEIG FAGERMOEN[2]

[1]*Hedmark University College, Faculty of Health and Sports, Elverum, & Modum Bad, Vikersund, and* [2]*Aker University Hospital & University of Oslo, Institute of Nursing and Health Sciences, Oslo, Norway*

Abstract
Background: The focus is voluntarily hospitalized patients' experiences during planned admissions at a psychiatric clinic.
Aim: To explore and describe patients' perceptions on what were essential experiences for their recovery processes.
Method: An exploratory and descriptive study, with a hermeneutic–phenomenological approach in data collection and analysis. Qualitative interviews with 15 patients during their stay.
Results: The patients' experiences of wholeness and self-worth in time and space were found to be decisive. Wholeness refers to a combination of professionalism, kind hearts, and aesthetic qualities of the place. Altogether this contributed to the patients' experience of self-worth and equality. Socializing with fellow patients was also important in this regard. The therapy programme during daytime facilitated patients' experiences of being active and equal with the staff. Leisure time allowed for being a fellow human among other patients. But for some this reinforced the experiences of being a patient, i.e., being passive and inferior.
Conclusions: It may still be useful to offer inpatient treatment for persons suffering from mental health problems. There is a need for further research to find what are the optimal therapeutic milieu and culture, and how these affect the recovery processes.

Keywords: *Patients' experiences, therapeutic culture, inpatient treatment*

Introduction

In most Western countries focus in the treatment of mental disorders has shifted from hospitalization to outpatient treatment. The number of hospital beds is reduced, and milieu therapy in institutions has to a large degree been shut down (Fakhoury & Priebe, 2002). However, there may still be a need for hospitalization for persons who do not respond adequately to outpatient treatment. An increasing number of people with mental disorders have become disability pensioners, and the majority of these do not have severe mental illness (Martinsen, 2004). Many seem to profit from staying in a stable therapeutic milieu over time (Gude, 2001).

In quantitative as well as qualitative studies patients generally have reported that the relationship between the patients and staff is the most important therapeutic factor. Relational factors such as empathy, interest and understanding, in addition to a safe therapeutic environment, have meant the most (Hansson et al., 1993; Rossberg, 2004). In

Correspondence: Lisbet Borge, Hedmark University College, Faculty of Health and Sports, N-2418 Elverum, Elverum, N-2418 Norway. E-mail: lisbet.borge@gmail.com

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qualitative studies the importance of the relations is more thoroughly explored (Johansson & Eklund, 2003; Letendre, 1997). Patients wish to encounter professionals who clearly invite them to establish a relationship, by reaching out and articulating care. A programme with a variety of opportunities for the common socializing of patients and staff is important (Cleary & Edwards, 1999; Lindström, 1997).

Other studies have assessed the significance of the ward atmosphere. Non-psychotic patients improve in ward environments characterized by high levels of engagement, spontaneity, autonomy and personal problem orientation. Patients prefer a moderate level of anger and aggression and low level of staff control (Friis, 1986). Psychotherapy research indicates that common factors, such as extra therapeutic and relational factors, are more important than specific technical interventions (Hubble et al., 1998). A confirming attitude can contribute to patient experiences of been seen and understood, and this may facilitate a favourable self-development (Vatne, 2003). In hospitals the physical environment is important, and art, culture and aesthetics have significant meaning to patients (Cold et al., 1998; Gross et al., 1998).

Most studies on inpatients have addressed patients with severe mental disorders (Lindström, 1997). Previous studies have shown that other patient groups with long lasting mental suffering improve considerably following inpatient treatment (Gude, 2001). There is, however, a lack of systematic evaluations from patients' point of view. Hence, the present study gathered personal experiences from patients suffering from mental health problems with planned voluntary admissions at a psychiatric clinic. The intention was to increase our understanding of the importance of a stay at the institution, and to identify elements which were experienced as beneficial or unfortunate. This kind of knowledge is particularly important in a time where the usefulness of hospitalization for patients suffering from mental health problems increasingly has been questioned. Davidson (2003) has underlined the significance of phenomenology in the development of knowledge within the field of psychiatry. Qualitative methods, investigating patient experiences from treatment, are useful contributions in this context (Malterud, 2001).

The primary purpose of this article is to explore and describe patients' perceptions on what were essential experiences for their recovery processes in hospital, in their encounter with the treatment and care culture.

Methodological approach

Setting

The study took place in a psychiatric clinic in Norway with 117 beds, offering pre-planned admissions for patients suffering from long-term mental health problems. The hospital has six wards of which three are staffed 24-hours a day. Several buildings in old Swiss style located in the countryside comprise the institution. The surroundings, indoors as well as outdoors, reflect an emphasis on beauty and pleasure, and the arts and culture are regarded as important for health. The facilities include a church, and the patients receive an offer of pastoral counselling. Equality, respect for the integrity of the human being, and a holistic view of man are sustaining principles at the place. Patients are hospitalized on an average for 12 weeks, and are offered various forms of psychotherapy, individually as well as in groups. The professional staffs consist mainly of nurses, psychiatrists and psychologists.

Sample

Selection criteria were to have a minimum of five patients from each of the three wards with 24-hour staff, variation across diagnoses and age, both men and women. The therapist or the primary nurse recruited patients. Purposeful sampling was used to obtain a material with sufficient depth and breadth to answer the research question (Malterud, 2003). A requirement for being accepted at the hospital was that previous treatment had been tried and failed. All had previously attended outpatient treatment, and some had also been inpatients at other hospitals.

A total of 15 patients, eight women and seven men, participated in the study. The mean age was 41.4 years (range 19 – 58), all ethnic Norwegian. The ICD-10 diagnoses were social phobia ($n = 3$), depression ($n = 5$), eating disorders ($n = 3$), post-traumatic stress disorder ($n = 3$) and borderline personality disorder ($n = 1$). The analysis began after 15 patients were interviewed. When interviews of 11 patients was analysed, the same themes were repeated. Substantial new themes did not emerge, and there was no need to recruit more patients (data saturation).

Procedure

The first author conducted tape-recorded qualitative interviews of 1½-hour duration about two weeks before discharge. The interviews were formed as a dialogue, and began with an open question: ''Tell me about a concrete experience from the hospital stay, which has been especially important to you''. A theme guide was used to give direction for the dialogue. They were encouraged to talk about positive as well as negative experiences. Examples of themes were: the context for treatment and care, everyday life at the hospital, attitudes from the staff, the impact of social support and other contextual factors. Together the patients and researcher explored the patients' experiences, views about being in the hospital, and their meaning to the patient (Giorgi, 1997; Kvale, 1996; van Manen, 1997).

Ethics

Patients received written and verbal information about the study. It was clearly stated that participation was voluntary, that they at any time could withdraw, and this would have no negative consequences for their current or later relationship to the clinic. They were informed that the interviewer was part of the management of the institution, but not directly responsible for treatment and care. Assurances were also made that all information given was confidential, and that anonymity would be preserved when the results were published. Written consent was obtained at inclusion. The project was approved by the Norwegian Ombudsman for Privacy in Research. The Regional Norwegian Committees for Medical Research Ethics was consulted, and the study was performed according to the Helsinki Declaration.

Interpretation and analysis

This hermeneutic – phenomenological approach to knowledge development focussed the lived experiences of patients and their interpretations of these (van Manen, 1997). The study design was exploratory and descriptive, using qualitative research interviews (Kvale, 1996).

The analytic process recommended by Malterud (2003), inspired by Giorgi's (1997) approach, was utilized. All interviews were tape recorded and transcribed verbatim. The first

reading of the text and repeated listening to the tapes provided a comprehensive understanding of what the patients communicated. A synthesis of this was written in the patients' own words. An open attitude to the text is important in this phase, and one seeks to put aside personal pre-understanding and theoretical frames of reference. In light of the research question a systematic review of the interview was commenced to identify meaning units. Subsequently, the contents of individual meaning units were abstracted. Colour coding was used to identify meaning units and classify central themes and sub-themes that were empirically grounded. A systematic de-contextualization was then carried out, by cutting and pasting text segments and quotes under the various themes. These were simultaneously evaluated in light of the theoretical framework of reference. This process followed the hermeneutical spiral principle, i.e., extracting parts and then putting them back together in a new meaningful whole. Finally, the refined categories were synthesized and the essential contents of the phenomena were formulated (re-contextualization). These four analytic steps comprise the main structure of the method known as systematic text condensation (Malterud, 2003), which first and foremost represents a hermeneutical in-depth understanding of meaning. Validation of the findings was done by systematically comparing contents and categories to the original material throughout the entire analytic process. Parts of the analysis were validated by an external consultant (the second author). Since any interpretation of data was done within a scientific perspective to find the essence of meaning and not the singular person's meaning, respondent validation was irrelevant (Giorgi, 2000).

Results

The patient experiences were comprised into two main categories: *Wholeness and self-worth* and *Time and space* with several sub-categories (Table I). All categories were formulated using the patients' own words. Quotes are used in the presentation to give room for the patients' own voices.

Wholeness and self-worth

Professionalism, kind hearts and beauty. The patients described being hospitalized as a condition for experiencing wholeness:

> It builds me up to know that I am important to others, and everyone is important to one another [. . .] It is difficult to describe it, but for my own part I find it to be empowering, and that has something to do with the experience of wholeness [. . .]. Nature, the house, buildings, plants; the delicate experience affects you and has an empowering effect. This means something. It instils a sense of self-worth.

Table I. Patients' experiences during hospitalization.

Main categories	Sub-categories
Wholeness and self-worth	Professionalism, kind hearts and beauty
	Atmosphere
	Meeting with fellow patients
Time and space	Significance of time
	Experiencing oneself as a patient in time and space

This experience of wholeness was described as ''professionalism'', ''kind hearts'' and ''the beauty'' in a good atmosphere. In different ways these factors combined to create an experience of having value as human beings.

Professionalism was associated with how professionals carried out their therapeutic activities, in addition to the patients' experience of receiving help in several areas of their lives. It particular it was pointed out that the staff in general knew what they were doing, and that they were strong enough to receive the emotions and reactions from the patients. The presence of the staff, good routines, structure and time schedule were associated with both professionalism and patients' experiences of being cared for. The most important was that the professionals knew their job, and in general this was the case. The good therapist was one who could ask the right questions, knew where he or she should push, gave feedback and who ''had both heart and head''. Some of the patients also told about episodes, where they had felt badly taken. This pertained to situations where they had experienced not being taken seriously. Several reported that they had been very conscious about whom among the staff they wanted to have contact with during their stay.

The kind-heartedness was related to the experience that patients and staff were ''like a family''. Compassion, to be seen and understood, the experience of equal worth, security, and to be called by one's first name gave an experience of self-worth. A kind heart was also about ''the good helpers'', who saw the patients and helped them to find their way to their inner selves. Several commented that they did not have a feeling of being in a patient role, because the atmosphere was familiar and social, and the personnel were not looking down on them. This contributed to increase the experience of equality.

The beauty was connected with aesthetic aspects, both inside and outside.

> It doesn't feel like a hospital [...] and that gives me a feeling of self-worth. It has to do with everything: The house, which is beautiful inside and outside, the artwork on the walls, the beautiful and elegant, peaceful surroundings. One becomes calm, and there is access to a church here. This place emanates warmth and confidence. It is connected with the architecture of the buildings and the attitudes of the people who work here. You are encountered warmly. The house has a joyful quality. Being here gives one the courage to live.

The patients reported that this gave them worth as human beings, security and feeling of not being alone. The physical setting contributed to positive energy, increased courage to live and motivation for treatment.

> [This institution] offers a different type of service. The hospital is open and free, and one comes into contact with staff and fellow patients. This type of hospital is extremely important in psychiatry.

Their feeling of being ''normal'' was confirmed. The beautiful buildings and the attitudes of the personnel seemed to contribute to decrease the feeling of stigmatization as psychiatric patients. The wholeness was also connected to the church beside the hospital.

> The church is constructed in such a way that it does not belong to anyone, everyone owns it. It is not a typical church building, and it is not a church either. There is a lot of tolerance, the church is open at all times, and it is possible to go in and sit down and be alone for a while.

Several visited the church for peace and silence, and experienced it as a firm basis in their existence. It gave them a feeling of anonymity, freedom and community, where they could come and go as they pleased. About one half of the patients said that the offer in the spiritual domain strengthened their experience of wholeness as human beings.

Atmosphere. When the patients described ''the milieu'', they spoke of the atmosphere, surroundings, culture, attitudes of staff, professionalism, a feeling of well being and community with fellow patients. This is illustrated by the following quote:

> There is something in the walls here. It is difficult to describe, but it is a totality of a number of things; the people who work here, the delicate aspects of the area, the grounds, the house and design. Many elements give an experience of wholeness and being accepted.

Also the way they were met by kitchen staff, janitors, gardener and house staff was mentioned in this regard. These worked to make the surroundings pleasant and beautiful, said hello and made eye contact. This increased the patients' self-worth. Security, which is a necessary condition to open up to others, was facilitated in the good atmosphere.

> Some of it one cannot see, only sense. It is just there, in the atmosphere, harmony. And then there is the sense of security that the personnel give you, which certainly has an effect on all the patients, who then give back the same. The security they might have within themselves also comes out.

Nice surroundings and atmosphere were important, even more so was the attitude of the staff in meeting with the patients. ''There is no culture for treating patients badly here, as there perhaps is in many other places''.

Several believed that the safe atmosphere influenced the encounters between fellow patients and contributed to their daring to come out with pent-up reactions and feelings. The security in such a milieu was important and made it easier to accept criticism, praise, and to manage new challenges. Some commented that how the staff met the patients was more important than their professional qualifications. ''One cannot be trained to be a compassionate human being. There was always such a good atmosphere when . . . [nurse assistant] was on the ward''.

The patients' feedback underlines the importance of ''the helpers'' having the ability to listen, express sympathy and confirm the patients through an attitude of acceptance. Coming together with professionals as human beings was an experience of meeting them as persons, and this created a good atmosphere.

Meeting with fellow patients. Time spent with fellow patients meant a great deal, in both a good and bad sense. This took place in structured group activities and during leisure time on evenings and weekends. When they met like-minded people, they felt less lonely and shameful. It was relieving to see that others also struggled with the same problems as they did themselves. Besides, they sometimes gave each other more response than they received from the staff.

> [. . .] the chance for receiving feedback is so much greater in that way, because we see each other in the milieu all the time [. . .] Even if one had sessions every day with a

> therapist, it is still not certain that they would have managed to give feedback. They would sit and work with the next client, and not be able to follow me up during the day.

It was easier to talk with fellow patients than with staff, because they experienced one another as equal and used the same language. They learned, cared about and were involved in one another, and thereby also changed perspectives on themselves.

But socializing could also lead to conflicts. This became particularly difficult if there were unresolved conflicts in the therapy group at daytime. This reduced the benefits of the hospitalization period. Those who had received help from staff in resolving conflicts viewed this as helpful and informative experiences.

Time and space

Significance of time. The term time was often mentioned in the interviews. Time appeared to have a decisive significance. Being hospitalized over a period of time was crucial to the therapy process.

> My individual therapist told me that now there were only four sessions left, while I thought I still had four weeks left of my stay, and I could talk with fellow patients and nurses in the group between sessions with the therapist.

Thus patients and individual therapists appeared to experience time differently. It was just as important to participate in the milieu as to work with an individual therapist. Many had previously received outpatient treatment, and had varying experiences with this.

> Being physically away from home means a lot, and not the least the continuity in the treatment programme itself . . . to be at peace in one place, that you don't have to leave here and go home. I find at any rate that I have a different sense of calmness in working with my things outside of the therapy itself in the daytime, outside of the programme. It is so much easier to go home from an outpatient session and think: OK, that was that session . . . Yes, I know that many times when I leave the group here or my therapist, I walk around a bit and think about what has been said and make some notes. But that is more difficult as outpatient, to go home and sit down and speculate about these things. At least, that is how it has been for me. The peace you find is very important, when you have a hospital stay at a place such like this.

Patients often described the outpatient sessions as fragmented. There were too long time spans between them, and the therapeutic processes were disturbed by everyday life at home. Time and calmness during the hospitalization helped patients to move forward. However, some had other opinions, and patients who struggled with taking initiative, often experienced having "idle time", which is illustrated in the following quote.

> [. . .] but we also have a lot of free time in the evenings and week-ends. That could have been spent reading articles to make progress in treatment.

These patients needed help to structure their time, while other patients had less need for this.

Experiencing oneself as a patient in time and space. Several were concerned about how vulnerable one is as a patient in a psychiatric hospital. The society's view of people needing psychiatric help was frequently commented on.

> I believe it is very important that the personnel is aware that it is tough for many to come here, extremely tough to take that step and move into an unfamiliar landscape.
>
> [. . .] I believe the general opinion outside is that there is something degrading about people like myself, who need to stay at a place like this.

Many patients spoke of it as embarrassing and shameful; they experienced being an inconvenience to others, in addition to feeling small and worthless. Others reported they were preoccupied with increasing their own awareness regarding the fact that they were patients, because they wanted to receive help and seize the opportunity to learn more. Together with fellow patients they did not think of themselves as patients but human beings. The negative aspect of being a patient emerged predominantly when they were together with the personnel in the evening.

> During daytime patients and staff are all on one level, while in the evening it becomes clear who are working and who are patients.

The breakdown in the equality in the evenings was associated with the nurses having other roles than during the daytime.

Patients referred to the time between 8 a.m. and 4 p.m. as ''daytime'' or ''therapy time''. In this period they produced something meaningful, and experienced themselves as responsible, active and equal to the personnel. They were a ''we'' working in a common space. ''Daytime'' consisted of a planned programme and was goal-oriented. After having worked hard and taking actively part in the programme, many experienced to have had a good day. If they felt lack of own initiative, and the therapists and nurses had only minimally stimulated or demanded something from them, many felt that the day had not been good. After 4 p.m. came the late afternoon and evening, referred to as ''leisure time''. Several experienced the transition from ''therapy time'' to ''leisure time'' as negative. Some felt that they disclaimed responsibility for themselves by becoming more passive, being looked after or becoming more insecure. Staff and patients were no longer equal.

> The average day is good, until dinner is over. After dinner it is unsafe, a long and unsafe afternoon and evening, and the night is not good.

But if the evening had been more like the daytime, it would have been different.

> You would avoid the transition from producing something good, and then suddenly evening comes, and you are supposed to sit in your room and be a patient.

The ward office amplified the transition for better or worse. Several commented that the ward office created distance and indicated a clearer distinction between staff and patients. The ward office was perceived as the staff's room, which sometimes also was occupied by other patients. Then the threshold for entering was even higher.

Insecure patients wanted personnel to take initiative and be visible. It was important that personnel were in common rooms and contributed socially, and thereby having contact with

them as persons on equal footing. When staff departed from their professional role, such encounters gave patients experiences of being met as ordinary human beings.

Patients with less need for staff in the evenings wanted a social meeting place open to all patients.

> I have found many likeminded people on the smoking porch; that is where I have got to know those outside of my group. I also have a need to get away from just being with those who know so much about me, get permission to be just a human being, who sits there and has a cup of coffee and relaxes. Then we are a gang of people, who just happen to be in the same place.

The meeting places could be, for instance, a winter garden without TV, or a café, with opportunities for socializing. Then the passive patient experience would be counteracted. This underlines the significance of personnel participating on the patients' various arenas.

Discussion

The point of departure for the study was how voluntarily admitted patients experienced the treatment and care culture at a psychiatric clinic.

Patients experienced a meaningful situation in hospital when the spirit of the *place* was good. This was reflected as good atmosphere, professionalism and kind-heartedness of the staff, and the beauty of the location. Patients experienced feelings of *wholeness* and of *self-worth*.

Patients and staff experienced the dimension of *time* differently. Being hospitalized over time, away from home, in a planned and goal-oriented day programme together with other patients, made the patients feel responsible, active and equal to the staff. This was considered as important for their recovery. Opposite was ''the leisure time'' in the afternoon and weekends: Staff and patients were no longer equals. Patients were left alone and felt more passive.

Feeling of wholeness was a constantly returning theme during the interviews. This is also a basic theme in nursing, and nursing philosophy almost universally includes a holistic approach towards human beings. The hermeneutics attempt to understand man as a cultural being and as a whole, by observing body, soul and spirit in interplay with the surroundings (Hummelvoll & Barbosa da Silva, 1994).

The place had a great significance, especially the beauty, but also the atmosphere, which was connected to the people who were there. The architect Norberg-Schulz (1980), referring to Heidegger's philosophy that being a human is related to places, writes about ''the spirit of a place''. He believes that to understand a place, it is essential to grasp the distinctive character or atmosphere of the place – *genius loci*. The living interplay between people at a specific place can provide new experiences, a place to be. The patients confirmed this. Many stated that the stay had given them greater worth as human beings. The place in itself had an impact, and created a feeing of fellowships among them. These elements are health promoting resources within the patients and their surroundings (Gross et al., 1998; Antonovsky, 1996).

Frankl (1985) described how the beauty of nature became a turning point for hope and a basis for his own identity during his stay in a concentration camp. His experiences can enlighten our understanding of why the patients found that the place and its atmosphere gave them courage to live.

van Manen (1997) argues that space, time and relations create a coherent whole in the life experiences of man. From this perspective, it is possible to describe the life world and experiences of patients with nuances and specificity.

Space (spatiality) includes both the experienced internal atmosphere, which can be friendly or unfriendly, and the external experience of a place, such as the aesthetic dimension.

Patients with previous experiences with outpatient treatment held that they had greater benefits from being hospitalized. They found peace away from their home environment and gained greater continuity of treatment. Being away from home and coming to calm and safe surroundings was an important deviation from their everyday life. This is an important reminder in our time of deinstitutionalization.

The experience of time, or lived time (temporality), alludes to a person's subjective temporal perception of past, present and future. Time can be experienced as short or long and have different meanings in various contexts. In this study time was experienced differently on the part of personnel and patients. The experience of time can be different in an institution, because it represents a break with ordinary existence.

Life in institutions is a waiting culture (Frankenberg, 1992). The patients experienced this when the late afternoon began. Then the relationship between personnel and themselves was experienced as more asymmetrical. The daily therapy programme was goal oriented, while the programme after 4 p.m. did not have specific objectives. The patients who managed to take initiative, experienced this time as meaningful. Those, who were more insecure, needed help in structuring time. With a little planning from the staff in advance, it is possible that these patients could be helped to use their time more constructively and take more responsibility for their own treatment.

The ward office reinforced the patients' feeling of being vulnerable and inferior. Goffman (1982) has described daily life inside psychiatric institutions, by applying the terms ''front stage'' and ''back stage'', to illuminate the public and private aspects, respectively. Maintaining the private space, away from observation and control, is an important ingredient of quality of live for most people, also during hospitalization. It is important to be aware of what kind of social space the personnel create in the hospital, and how they use their time. In this study many patients wanted a social meeting place, where they could relax and socialise with patients from other wards in the hospital, without being observed by the staff.

Living relations (relationality) describe the experiences for better or worse in relation to other people in time and space. A living relation can be experienced as positive, safe and protective or the opposite; judgemental, demanding or unsafe. Good relations can contribute to maturation, health and learning, while negative relations can lead to insecurity and development of illness.

Many emphasized in particular the relationship to nurses and fellow patients. Most interviews emphasized the importance of socializing and meeting fellow patients. With a few exceptions, they told about how contributions from fellow patients had been important in their own recovery process. This confirms findings from earlier studies in milieu therapeutic wards (Lindström, 1997).

Helping relations, holistic dialogues, authentic encounters and an ethical orientation were emphasized (Hummelvoll & Barbosa da Silva, 1994). The patients emphasized these aspects more than the technical skills and academic education. This corresponds well with recent trends in psychotherapy research, where the quality of relations is emphasized as being the most important (Hubble et al., 1998; Johansson & Eklund, 2003).

Nurses have a key role in the ward milieu, and often have the function of ''libero'' in the treatment programmes (Hummelvoll, 1996). They also meet the patients more informally,

and the relationship can have different aims. Sometimes the defined goal is psychotherapeutic, while they at other times can depart from their professional role. They meet the patients in different spaces and at other times of the day, as they often work on a rotating schedule. Thereby the patients may get to know them in different ways. They have more time with patients without goal-oriented activities, so-called *kairos time*. The patients have most *chronos time* with their therapists, because psychotherapy is scheduled to specific days at specific times and in a specific space. It is probably beneficial for patients to experience both kairos and chronos time (Sommerfeldt, 2005).

Creating a good therapeutic milieu is important for the recovery processes, and this is a constant challenge for the staff. Most patients prefer a lot of interaction between patients and staff (Lindström 1997; Rossberg, 2004). This was confirmed in the present study, where patients were satisfied with the treatment during the daytime. For some patients, time outside the scheduled activities was experienced more negatively, as many had been rendered passive and dependent. It is of utmost importance that the members of the staff try to empower patients, helping them to take responsibility and being in command of their own lives also outside the planned activities (Gibson, 1991).

Methodological limitations

The study has some limitations. Being a researcher at one's own working place has positive as well as negative aspects (Coghlan & Cassey, 2001). It was an advantage to know the context where the patients were living when interviewing, but also made it more difficult to take total unbiased attitude. In any semi-structured interview interaction between interviewer and interviewee influence the quality of outcome. Thus, one possibility is that patients have narrated things in a way that pleases the interviewer. However, to reduce bias a continuous conscientious open and listening attitude combined with reflexivity was utilized (Malterud, 2003). It is impossible to know whether the patients were more positive in their statements than if an external researcher had interviewed them. The impression during the interviews was that most patients appreciated the opportunity of being allowed to communicate their experiences for better or worse. In addition, several expressed appreciation of being interviewed by a person from the management. This gave them a feeling of being taken seriously. Critical reflection throughout the entire research process, especially in the systematic analysis of the interviews, facilitated a necessary distance to what the patients communicated (Fagermoen, 2005; Graneheim & Lundman, 2004; Malterud, 2001).

Conclusions

This study indicates that inpatient treatment provided something that patients did not receive as outpatients. It may still be important to offer hospital stays for persons who do not have severe mental disorders.

A combination of professionalism, kind hearts, and aesthetic qualities of the place, contributed to the patients' experience of self-worth and equality. Being away from home socializing with fellow patients was also important in this regard. The therapy programme during daytime facilitated patients' experiences of being active and equal with the staff. Leisure time allowed for being a fellow human among other patients. But for some this time reinforced the experiences of being a patient, i.e., being passive and inferior.

The limited knowledge about how the staff can help patients to be more active in their own treatment calls for. There is a need for knowledge to understand how the treatment

milieu should be organized to promote in the best possible manner the patients' recovery process, and how the various professions can collaborate in this.

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